



Advanced Gastroenterology, PLLC
Advanced Endoscopy, PLLC
2415 NE 134th Street, Suite 205
Vancouver, WA 98686
360-576-5060

AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____ Birth date: _____

Street Address _____ City _____ State _____ Zip _____

SSN: _____ Daytime Phone: (____) _____ Cell/Work Phone: (____) _____

I authorize you to **OBTAIN** health care information **FROM**:

Physician Name

Clinic/Hospital Name

Street/Box

City/State/Zip

Fax: (____) _____

I authorize you to **SEND/DISCLOSE** health care information **TO**:

Self/Patient

Physician Name

Clinic/Hospital Name

Street/Box

City/State/Zip

Fax: (360) 576-1133 **PLEASE FAX RECORDS**

You may use/disclose the following information:

- All health care information in my medical record
- Health care information relating to the following treatment or condition: _____
- Health care information for the date(s): _____
- Immunization information
- Radiology films-date(s) or type(s): _____
- Other: _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):

- HIV, HIV-related illness, AIDS, Aids-related illness
- Sexually transmitted diseases
- Psychiatric disorders/mental health treatment
- Drug and/or alcohol use

Reason for Disclosure: Referral/second opinion Transfer or Care Insurance application/benefits

This authorization ends (this document does not permit disclosure of health information created more than 90 days after the date it is signed):

- 90 days from date it is signed On (date): _____
- When the following occurs (no longer than 90 days from date signed): _____

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Advanced Gastroenterology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter to Advanced Gastroenterology. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. **There may be fees for providing copies.**

Patient or legally authorized representative signature

Date and time

Relationship to patient (if not by patient)

Printed name if signed on behalf of patient